

Dr. Green,

Do you know this one?

No

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LOCAL FILE NUMBER

26-160

CERTIFICATE OF LIVE BIRTH

STATE OF UTAH — DEPARTMENT OF HEALTH

STATE BIRTH NUMBER

CHILD	CHILD—NAME FIRST MIDDLE LAST 1. Aaron Tyler Sperry	SEX 2. Male	DATE OF BIRTH (Mo., Day, Year) 3a. August 16, 1981	HOUR (24 hr. clock) 3b. 7:45
	PLACE OF BIRTH—HOSPITAL NAME (If not in hospital, give street and number) 4a. Home-Daniels	CITY, TOWN OR LOCATION OF BIRTH 4b. Daniels	COUNTY OF BIRTH 4c. Wasatch	
CERTIFIER	I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE. 5a. Signature 5b. CERTIFIER'S NAME AND TITLE (Type and check box) Hospital Administrator <input type="checkbox"/> Designated Representative <input type="checkbox"/>		I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE. 6a. Attendant Signature 6b. ATTENDANT—NAME, TITLE (MD, DO, Certified Midwife, other) (Type or print) 6c. Fern Bronson-Midwife	
	DATE SIGNED (Mo., Day, Year) 5c.		LICENSE NO.	
REGISTRAR	REGISTRAR—(Signature) 7a. [Signature]	DATE RECEIVED BY REGISTRAR (Mo., Day, Year) 7b. 8-24-81	MAILING ADDRESS OF ATTENDANT (Street or R.F.D. No., City or Town, State, Zip.) 7c. P.O. Box 563 West Jordan, Utah	
MOTHER	MOTHER—NAME FIRST MIDDLE MAIDEN NAME 8. Pamela Peatross	DATE OF BIRTH (Mo., Day, Year) 9. July 26, 1943	AGE 10. 38	STATE OF BIRTH (If not in USA, name country) 11. Provo, Utah
	RESIDENCE—STREET AND NUMBER OF RESIDENCE 11a. Daniels, Utah	CITY, TOWN OR LOCATION 11b. Heber	INSIDE CITY LIMITS 11c. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	COUNTY 11d. Wasatch
	MOTHER'S MAILING ADDRESS—If same as above, enter Zip Code only. STREET ADDRESS OR P.O. BOX NUMBER 12a. P.O. Box 308	CITY OR TOWN 12b. Heber	STATE 12c. Utah	ZIP CODE 12d. 84032
	FATHER—NAME FIRST MIDDLE LAST 13. Norman Karl Sperry	DATE OF BIRTH (Mo., Day, Year) 14. July, 29, 1944	AGE 15. 39	STATE OF BIRTH (If not in U.S.A., name country) 16. Utah
INFORMANT	I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. (Signature of Parent or Other Informant) 16a. Norman K. Sperry			RELATION TO CHILD 16b. Father

PRIVATE INFORMATION FOR MEDICAL AND HEALTH USE ONLY

TO BE COMPLETED BY PARENTS	SPANISH ORIGIN?		USUAL OCCUPATION—(Kind of work usually done even if not currently employed) Specify		PREGNANCY HISTORY (Complete each section)			
	Mother: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, indicate <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Of Spanish origin not listed; Specify	Father: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> If yes, indicate <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Of Spanish origin not listed; Specify	MOTHER 18a. Homemaker	FATHER 18b. Truck Driver	LIVE BIRTHS (Do not include this Child)		OTHER TERMINATIONS (Spontaneous and Induced)	
	17a. RACE Specify White, Black, American Indian, Etc. MOTHER 21a. White		17b. RACE Specify White, Black, American Indian, Etc. FATHER 21b. White		19a. Now living No. 5 <input type="checkbox"/> None	19b. Now dead No. <input checked="" type="checkbox"/> None	19c. Before 20 weeks No. <input type="checkbox"/> None	19d. After 20 weeks No. <input checked="" type="checkbox"/> None
	20a. 12		20b. 12		DATE of last Live Birth (Mo., Year) May 14, 1974		DATE of last Other Termination (as indicated in d or e above) (Mo., Year) October, 1977	
TO BE COMPLETED BY PHYSICIAN OR FROM MEDICAL CHART	THIS BIRTH Single, twin, triplet, etc. Specify 24a. Single		If not single birth—Born first, second, third, etc. Specify 24b. third		COMPLICATIONS OF PREGNANCY (Describe or write "none") 25. None			
	DATE Last normal menses began (Mo., Day, Year) 26. Nov. 15, 1981		Month Pregnancy Prenatal Care began (first, second, etc.) Specify 29. 10		CONCURRENT ILLNESSES OR CONDITIONS AFFECTING THE PREGNANCY (Describe or write "none") 28. None			
	APGAR SCORE 1 min 8 5 min 9		PRENATAL VISITS Total No. (If none, so state) 29. 10		DELIVERY (Check One) <input checked="" type="checkbox"/> 1. Cephalic <input type="checkbox"/> 2. Breech <input type="checkbox"/> 3. Other		Method (Check One) <input checked="" type="checkbox"/> 1. Spontaneous <input type="checkbox"/> 2. Low Forceps <input type="checkbox"/> 3. Mid Forceps <input type="checkbox"/> 4. Primary C-Section <input type="checkbox"/> 5. Repeat C-Section	
	BIRTH WEIGHT (Grams) 32. 3515		BIRTH WEIGHT (Grams) 32. 3515		CONGENITAL MALFORMATIONS OR ANOMALIES OF CHILD (Describe or write "none") 33. None			